UNIVERSIDADE DE LISBOA

FACULDADE DE PSICOLOGIA

DARING TO INFLUENCE PERSONALITY VIA ZOLTAN GROSS' APPROACH TO PSYCHOTERAPY:

An Experimental Study on Appraising Interventions Focused on Habit Validation vs. Habit Interruption

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Dissertação orientada pelo Prof. Doutor Nuno Miguel Silva Conceição

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Abstract

Zoltan Gross (1992; in press) offers a bold approach to therapy focused on personality change. Because habits are reinforced by their validation, breaking dysfunctional behavior patterns will sometimes mean denying this validation. Gross' approach is a balancing act between the need to maintain a strong alliance and pulling clients out of their comfort zones.

A study by Lopes (2018), working from Zoltan Gross' principles, found therapists preferred validation to habit interruption. We investigated the preference and reasons behind it.

This between-groups study sorted participants into three experimental groups. Each group was exposed to a video showing a therapist in session, Gross, performing either habit validation (HV) or one of two types of habit interruption (HI): of self-presentation (HIsp) and of emotionality (HIe). We asked participants to rate his performance. We constructed rating scales for therapist's focus on habit intervention and for therapist's facilitative interpersonal skills. We then showed participants one video where client and therapist mend their alliance and asked if they would change their previous ratings after watching this.

Groups were compared through the Bonferroni procedure. Participants in HV approved significantly more of the therapist than participants in either HI. This aligns with Lopes' results. Focus on habit intervention did not differ between groups. Facilitative interpersonal skills' ratings differed between HV and HI. There were no significant differences between both HI, for any of these measures. Participants in HIsp were most inclined to increase their previous ratings, followed by HIe, then HV. A chi-square test suggests these distributions were not independent of manipulation.

Implications were discussed for therapy focused on personality change and testing for the Zoltan Gross approach.

Keywords: validation; habit interruption; facilitative interpersonal skills; self-presentation; personality change; Zoltan Gross approach

Resumo

Zoltan Gross (1992; na prensa) oferece uma abordagem arrojada à terapia focada na mudança de personalidade. Como hábitos são reforçados pela sua validação, quebrar padrões comportamentais disfuncionais às vezes significará negar esta validação. A abordagem de Gross é um ato de balanceamento entre a necessidade de manter uma aliança forte e puxar clientes para fora das suas zonas de conforto.

Um estudo por Lopes (2018), baseado nos principios de Zoltan Gross, revelou que terapeutas preferiam validação a interrupção de hábitos. Investigámos a preferência e as razões dela.

Este estudo entre-grupos sorteou participantes por três grupos experimentais. Cada grupo foi exposto a um video exibindo um terapeuta em sessão, Gross, a realizar ou validação de hábito (HV) ou um de dois tipos de interrupção de hábito (HI): a de *self-presentation* (HIsp) e de emocionalidade (HIe). Pedimos aos participantes para avaliarem a sua performance. Construímos escalas para o foco do terapeuta na intervenção nos hábitos e para as capacidades interpessoais facilitadoras do terapeuta. Depois apresentámos aos participantes um vídeo onde cliente e terapeuta reparam a sua aliança e perguntamos se mudariam as suas avaliações anteriores depois de verem isto.

Grupos foram comparados através do procedimento de Bonferroni. Participantes em HV aprovaram significativamente mais o terapeuta que participantes em qualquer HI. Isto está em linha com os resultados de Filipe. O foco na intervenção nos hábitos não divergiu entre grupos. Capacidades interpessoais facilitadoras divergiram entre HV e HI. Não houve diferença significativa entre as HI para nenhuma destas medidas. Participantes em Hisp tinham a maior inclinação para melhorarem as suas avaliações anteriores, seguidos pelos participantes em HIe, e por último HV. Um teste chi-square sugere que estas distribuições não foram independentes da manipulação.

Foram discutidas as implicações para terapia focada na mudança de personalidade e a testagem da abordagem de Zoltan Gross.

Palavras-chave: validação; interrupção de hábito; capacidades interpersoais facilitantes; self-presentation; mudança de personalida; abordagem de Zoltan Gross

Theoretical Framework

The therapeutic alliance and it's ruptures

While working to produce lasting changes, the therapist has to balance that ultimate goal with more immediate goals relating to the therapeutic alliance. For the past decades, it has become increasingly apparent that the quality of the relationship between therapist and client is a reliable predictor of positive therapy outcomes, however they are measured, across the different schools of psychotherapy (Ardito & Rabellino, 2011; Flückiger, Del Re, Wampold & Horvath, 2018). The establishment of the therapeutic alliance is a priority in the very first stage of the whole therapeutic process (Teyber & Teyber, 2017). The very concept of alliance stresses the active role that the client takes in the process – just as the therapist commits to try to help the client, so does the client commit to try to be help being helped – rather than being the passive recipient of a cure. It's about working together. Though, ultimately, a therapist would hope to promote greater free agency in his client, not just handholding the client through life. Trust is foundational for this alliance as for all alliances. When it is lost it must be regained. The client voluntarily shares with the therapist because he trusts that the therapist will be accepting of the clients' input. In this, it is generally advised that the therapist takes a non-judgmental posture. But trust can waver, like when the therapist responds in a way the client does not like or fails to respond. A therapists' insufficient empathic understanding might drive the client to wonder what is the point in sharing. These stumbling blocks in the ongoing therapeutic alliance are ruptures.

There has been a sizable string of studies relating to how the alliance can suffer ruptures and how therapists can identify this and deal with it to mend the alliance.

Safran and Muran (1996) define ruptures in the therapeutic alliance as deteriorations in the relationship between therapist and patient. They are patient behaviors or communications that are interpersonal markers indicating critical points in therapy for exploration. Often, these ruptures occur when therapists activate the clients' dysfunctional habits associated with interpersonal relations.

Saffran, Muran, Samstag, and Stevens (2001) recognize the negotiation of ruptures in the alliance as being at the core of the transformation process. The negotiation between the needs of the self and the needs of others is an ongoing challenge through life and it is there in the therapeutic process also. Many clients' complaints relate to this challenge and therapists may play a role in impressing on their clients the extent to which

the world can be negotiated with and to which they may have to compromise themselves to keep relationships.

The therapeutic alliance as an interpersonal relationship

The ways people tend to relate to one another tend to be reach far back in time, into childhood, and these attachment patterns will be there in the therapeutic setting, as they will be out in the world, shaping how the therapeutic alliance is established (Miller-Bottome, Talia, Safran, & Muran, 2017).

In childhood, clients might've had their affective needs consistently invalidated or not validated enough, so that they developed habits to cope. A behavior stemming from relationship needs that was invalidated would be less likely to reoccur, because invalidating feedback is painful and the child will want to avoid pain. This would carry over to future relationships. On the opposite end, a needy person might've felt that she only got enough validation from others, and this validation could be from something as basic as attention, by acting out. Validating feedback isn't necessarily pleasant to the seeker, but it is what the seeker craves – what we can call affect hunger, as we'll elaborate ahead (Gross, 1992; Gross, in press). When habits help the seeker attain validation, they are reinforced.

Furthermore, Miller-Bottome et al. (2017) explained how differences in attachment style predict clients' ability to participate in the mending of ruptures. While both secure and insecure clients experience ruptures sometimes, insecure clients are less able to express their emotions and needs. The therapists might do well to seek clues as to whether the clients are withholding their feelings, especially negative ones.

Safran et al. (2001) remarked that clients may hold back on sharing negative feelings about the process because they worry about how their therapists might react. Because expressing and working these feelings appears important to the process, they suggest that therapists invite their clients to express their negative feelings. A therapist would then respond with openness and without defensiveness, accepting their share of responsibility for the rupture. This exploration of the client's negative feelings could help the mending of the rupture. This is easier said than done. For therapists in training, at least, it is harder to identify these ruptures where the client withdraws emotionally than those ruptures where there is confrontation (Kline et al., 2018).

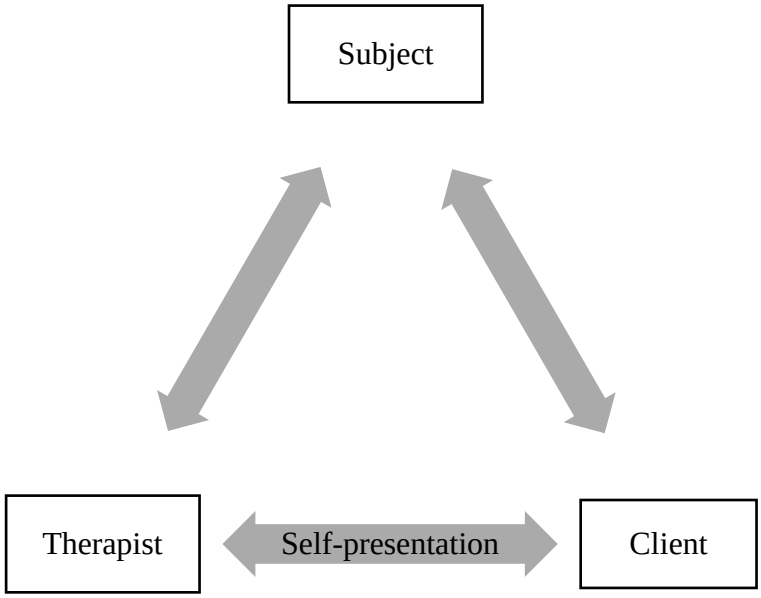
By calling the clients' attention to the expression of their withdrawn feelings, the therapists might enhance clients' awareness of what they are feeling (Safran, & Muran,

1996). These withdrawals may be the result of habit formation. These habits might function without the clients being aware of them and this lack of awareness of them keep clients from acting on them even though they may be dysfunctional (Gross, 1992; Gross, in press). These habits reveal themselves in interpersonal interactions including those that occur within the therapeutic dyad, where the therapists get the opportunities to help their clients work on them – Gross goes further and proposes the dyadic triangle.

Zoltan Gross' (1992; in press) dyadic triangle regards two levels of interaction in the dyadic relation: the baseline and the subject - or apex of the triangle (fig 1). Through dialogue, the subject matter comes between the participants and stays in the foreground of their awareness. But in the background, there's an ongoing striving from both participants for validating feedback from each other. It may or may not be related to the subject. An instance of this would be a therapist trying to present himself as a smart person to the client or a client trying to present himself as a nice person to the therapist. It is validating to feel like our self-presentation causes a desirable impression of ourselves in the other person. And it is unpleasant when we feel invalidated, like when we are insulted, disrespected or misinterpreted. This sort of communication occurs on the baseline. It usually runs covertly as opposed to the overt subject matter. When it does occur overtly, the persons feel passionately about each other or the subject matter - love or anger, specially. Self-presentation is mostly governed by habits that come up with interpersonal interaction and so is automatic.

Figure 1.

The Dyadic Triangle



Habit and personality formation through interpersonal relationships

According to Gross' theory**,** self-presentation is public manifestation of the character structures that vie to get validation from other people. Self-presentation bundles together habits that help humans maneuver their social environments towards attention, love or whatever else will nourish the seeker's affect hunger. By affect hunger, Gross (1992; in press) refers to brains' need for certain types of stimulation: "We seek validating feedback from others to stabilize the structures of our personalities for the same reasons we exercise our muscles to keep them in good operating shapes" (Gross, 1992, p. 54). Social interaction is the source for much of the stimulation that the brain calls for. Self-presentation habits will manifest within the dyadic therapeutic interactions, at the baseline level, as they usually do in other social interactions clients have throughout their daily lives. They are seldom the subject of most interactions and people respond to each other's presentations while adjusting their own, without deliberation as these are habituated. How people present themselves has implications to the interpersonal problems their public identities and their deeper selves face.

Character structures can become fixated by trauma and the habits thereof can go on to be reinforced throughout life as these structures' habits tend to vie to equilibrate and perpetuate the very same structures. Because this trauma can so often be traced back to childhood, personality disorders often are derived from fixated childhood character structures. These character structures were developed to nourish and protect the child's

affect hunger and so the adults with personality disorder may be unwittingly still trying to nourish and protect the children that they used to be (Gross, in press). Disordered personalities will go on repeating the same "childish" maneuvers they developed to satisfy their childhood needs unless the underlying character structures are thrown out of the context they usually operate in and thrown into novel contexts to which the brain must change to adapt. Therapists can break the dysfunctional patterns as they manifest in the interpersonal, therapeutic relationship with novel social interaction to which their clients are not habituated to.

Habit formation and interruption through feedback

Gross (1992) argued that by becoming aware of these habits, these become not so automatic and the underlying personality structures become more pliable to lasting change. Just like these habits became strong by repeated practice and rehearsal over long times, so too can they be weakened by repeated interruption.

Habits, while they might be maladaptive, endure because they are somehow reinforced. In the case of emotional withdrawal, clients might be motivated to avoid potentially unpleasant consequences of emotional expression, whether they are aware of it or not. Character structures can become fixated by trauma So habits can function as defenses, but to construe the clients' emotional withdrawal, or avoidance of certain types of emotions, as resistance against the therapist's prodding is dangerous.

Activating or acting against these defenses, these anxiety-avoiding habits, can induce ruptures in the alliance, as can any action that pulls a client outside his comfort zone. If therapists miss or avoid these habit-activating ruptures, those same habits will continue indefinitely because they aren't being interrupted (Gross, in press).

These habits integrate the person's personality and the person will often seek, possibly without realizing, to reinforce them and stabilize the associated personality structures, or character structures as Zoltan Gross (in press) names them. Interruption, that halting process, is central to Zoltan Gross' (1992) approach: "System-incompatible information disequilibrates the system, interrupting it's steady-state process, and deautomates it, creating an opportunity for change and growth." (p. 162).

Habit interruptions can thus be emotionally deregulatory, especially the ones that bring about intense pain or pleasure to people that lack the affect regulation skills to tolerate, moderate and learn from those experiences (Safran & Belotserkovsky, 2009). Clients' reactions to being pulled outside their comfort zone might include surprise or

more unpleasant responses to the therapist. So Safran and Belotserkovsky (2009) recommend that therapists themselves develop their affect regulation skills to manage the emotional responses the clients bring up from them – which will not always be pleasant. The therapist that feels the need for validating feedback from the client might feel inadequate or resent the client for failing to deliver. The therapist should be acutely aware that the client may have no voluntary control over such emotional processes. If not, the therapist may feel like blaming the client for doing something wrong and this assigning of guilt may hurt the baseline process (Gross, 1992).

Ultimately, ruptures must be mended for the sake of the therapeutic alliance that they threaten, but they are themselves opportunities to deepen that same alliance through their mending (Safran & Muran, 2000; Stevens, Muran, & Safran, 2003). Working through these ruptures might promote change, as their successful repair correlates to better client outcomes (Safran, Muran & Eubanks-Carter, 2011).

Therapists' own habits

Lopes (2018) conducted a study on the intervention choices therapists would do, out of an available set for selection, in response to short 3 minute video excerpts of clinical sessions. Given options for both habit-validating interventions and habit-interrupting interventions, most therapist preferred habit validation. Roughly one third chose interruption over validation. This overall trend persisted under the different experimental manipulations, albeit not unaffected. On one level, the participants in different experimental groups were subjected to different visual stimuli. A portion of the participants were subjected to complex stimuli, with images drawing from Gestalt's figure/ground illusion and instructions for the video watching task, while the rest was subjected to simple stimuli, with plain images and no such instructions. The participants were instructed to alternate focus between the levels of the figure/ground illusions. That task was meant to promote alternation of the focus between the verbal content of the client's communication and the emotional context for that communication, including how the client was communicating and how the therapist was feeling about that. It could be said that the manipulation was expected to prime the participant to engage more or less with the baseline (at the background of awareness) or with the subject (at the foreground of awareness). On top of that, there was a second level to the manipulation, whereby some participants were primed to focus on personality change and some participants were primed to focus on symptom change. Both the complex stimuli and the priming for

personality focus slightly promoted habit interruption, but habit validation responses were still more frequent. The frequency for picking validation instead of interruption never dropped below 70% for any group, even when the author considered the habit interruption responses better for promoting personality change. We postulate that therapists might shy away from habit interruption and such types of intervention if they are more apprehensive about how the clients will respond to them because of how it makes them feel.

It may be the therapists' own drive for controlling their self-presentation that inhibits behaviors that they expect wouldn't be as appealing to their clients. Because the therapist, as a person, carries habits vying for mental stability through their own validation. The evocation of too much emotion towards or against themselves, specially love or anger, may take the therapists outside the scope of intimacy they feel apt to handle and that they for which they have their own habits ready, perhaps just behind their awareness.

Understanding that even therapists are driven by their need of validating feedback to manage their self-presentation with their clients, it might be a concern the extent to which therapists may be impaired by a felt need to be "nice" and avoid stressful interpersonal conflict. Of course, niceness also encompasses a roster of desirable characteristics and behaviors that help people maneuver their social environments to satisfy their needs and wants, including that avoidance of conflict. And because niceness can fulfill needs and wants it is habit-forming. It often comes up when strangers meet: most of these interactions are characterized by surface-level acceptance and automated pleasantness (Gross, in press). These social scripts can constrain people's capacity to express themselves meaningfully, even if this automation regularly makes life simpler, as automation often does.

On the other hand, it's evident that many of the qualities we associate with niceness can be equated with specific abilities linked to social interaction that have been found to predict positive therapy outcomes.

Anderson, Ogles, Patterson, Lambert, and Vermeersch (2009) include empathy, in their facilitative interpersonal skills (FIS) model, together with verbal fluency, emotional expression, persuasiveness, ho hopefulness, warmth, alliance-bond capacity, and problem focus. The FIS score had a correlation with therapy outcome close to .47, making the authors' multilevel model being verifiably predictive. Demographic data on the therapists, like age and theoretical orientation, were collected. Of these demographic variables, only age predicted outcomes. When age's effect was analyzed together with

FIS, however, only FIS explained the variance between outcomes. It could be that these interpersonal skills mediated the effects of age, as practice and experience could hone the therapists' skills.

The model was vindicated again by Anderson, Crowley, Himanwan, Holmberg and Uhlin (2015), with high FIS therapists' effects outperforming low FIS therapists' effects. This was achieved while accounting for the therapists' training status, to isolate technical factors from the common relational factors that make up FIS. FIS was found to be predictive of therapy outcomes independently from those technical factors. The changes produced were measured by comparing clients both before and after the therapy process and between the therapy sessions. Better FIS scores predicted better aliances, as measured by both therapists and clients. Furthermore, FIS was found to predict positive symptom change (Anderson, McClinkton, Himawan, Song, & Patterson, 2015).

Facilitative interpersonal skills' dimensions largely overlap with some common factors that hold up predictive power for beneficial therapy outcomes across a wide range of theoretical orientations, like alliance, empathy and expectations (Wampold, 2015). Anderson et al's FIS model is singled out here for it's emphasis on interpersonal interaction and therapist effects. Wampold, Baldwin, Holtforth and Imel (2017) describe how the individual therapists' characteristics have historically been neglected as study subjects, despite them being shown to have meaningful impacts upon therapy outcomes. Overall, research tended to fall on the role of the techniques that therapists used while overlooking the technicians themselves.

Outwardly, several of the characteristics that make effective therapists could be described as nice. Niceness is can be trained and is done so starting from childhood. While it also encompasses habits that help the nice children navigate their social environments, it also refers to habits that serve to validate the personal presentations of others, without regard to the nice ones' own feelings (Gross, in press). This makes it harder for them, as adults, to address the baseline dialogue activity, to express and engage with stronger emotions, unless they are also trained to do so. Could there be a sadder picture than a therapist that is afraid to talk about "bad" feelings?

Cartwright and Gardner (2016) explained how trainee therapists' lack of experience when they are initiating their practice leaves them overly sensitive and prone to doubting their abilities. This is a necessary step as no-one is born a therapist and every therapist must be trained. The authors find that trainees suffered from an heightened sense of self and felt their personal identity an unwelcome intrusion into the therapeutic dyad.

This relates to the therapists' anxiety over being rejected by the client. The therapists' own need for validating feedback from the client is a factor that must not be discounted. Trainees' self-definition process can have significant impacts on their capacity to empathize and engage with the client (Cartwright & Gardner, 2016). Ideally, the therapist would require never impose his emotional needs for validation on the client, but this takes much practice (Gross, in press).

There is always the potential for misunderstandings, unintentional offenses, and no end to the possible reasons why people might lash out at each other. Addressing these potential signs of interpersonal conflict or ruptures can be hard for new therapists to do, in a non-defensive way or at all, because it might suggest that the process or that isn't going so well. In Gross' (1992) triangle model, it can be said that these conflicts usually stick to the baseline, away from the subject which might even be changed to further distance the dyad participants from what can be a potential source of anxiety. Teyber and Teyber (2017) point out that "If therapists allow their own anxiety to keep them from asking clients about such potential signs of resistance, ambivalence, or rupture, their clients will be far more likely to act on these concerns and drop out of treatment prematurely" (p. 74). To better address these risks of rupture, therapist should be aware of how they habitually respond to interpersonal conflict, how they "tend to react to criticism, negative evaluations, or unwanted confrontations" (Teyber & Teyber, 2017, p. 90). For Gross (in press) this meant the therapist must have a willingness to, over many hours of practice, to endure the pain of invalidating confrontations triggered by the therapist's interrupting of the client's automatism.

A measure of professional self-doubt (PSD) might not be without merit. Nissen-Lie, Monsen, Ulleberg, and Rønnestad (2013) found that therapists doubting their own ability to help their clients was a factor correlated with positive therapy outcomes. This could suggest that reflective self-criticism plays an important, measurable role in helping therapists hone their practice (Nissen-Lie, et al., 2013; Nissen-Lie, et al., 2017).

While self-reflection can expose therapists, as with all people, to their own unpleasant feelings, it can also inform them of their own needs, wants and reactions to their clients that can impact the dyad and direction of the therapy process (Gross, 1992; in press; Stevens, Muran & Safran, 2003; Williams, Judge, Hill & Hoffman, 1997).

Present Study

We found necessary to check if therapists did have such a strong preference for habit validation (HV) over habit interruption (HI) as previously found (Lopes, 2018). We sought to provide our therapist participants with realistic instances of each type of intervention being preformed by an expert so they could judge these for themselves.

To deepen our understanding of the preference, we measured it with two "approval" variables: the self-reported likelihood of intervening like our expert and the overall performance rating.

If the HI instances were consistently rated worse than the HV, that could suggest that interventions directed at stopping clients' dysfunctional patterns of behavior and thought and promoting long-term change were being undervalued or appreciated less than interventions that brought present comfort to the client? While validation is a very important part of psychotherapy, especially in the building of the therapeutic alliance, breaking bad habits is difficult when stressful situations are consistently avoided and perhaps even more so when clients' prompts for validating feedback, which can be part of their dysfunctional patterns, are reinforced.

Furthermore, how could we tell that therapists were paying attention or reflecting on the habit-changing potential of different interventions? We attempted to construe a measure of this focus on habit intervention for ourselves and use it to check if therapists would use such focus when asked to judge examples of HV and HI.

Breaking down niceness into something measurable for the sake of our experiment required us to link this measurement to the experts' behaviors that the participants could observe and judge. We picked the perception of our expert's facilitative interpersonal skills as a dependent variable on which we would measure the effects of observing habit intervention vs. habit interruption. Would our participants be less likely to intervene like our expert when they perceived our expert to be not-so-nice? Note that as we've previously argued, validation is a necessary component of the therapeutic process and of building the therapeutic alliance, especially.

In either case, it would be expected that participants' perceptions' of our expert's FIS to differ between HV and HI. HV seems intuitively safer and nicer because of their great importance in building the therapeutic alliance. HI might activate more insecurities because of the added risk of conflict and alliance rupture. The FIS model informed our item design, but, given the format limitations of our short survey study, we adapted it's concept to a scale of our own design.

Lastly, would therapists change their minds about how adequate an intervention was if, after the stressful moments had passed, they observed the client and the client's therapist mending their bond?

Method

Data collection was done through a Qualtrics Survey Software online platform distributed via e-mail to mental health clinicians, over the course of 11 days.

Participants

A total of 102 clinicians responded, with an overwhelming majority (94,1%) self-identifying as psychologists. The gender ratio for the sample was even. US nationals (82,3%) made up most of the sample.

For the respondents that opted to provide the data the mean age was 61.75 (*SD* = 13.97) and 30.74 years of clinical experience (*SD* = 13.66). Respondents were asked to rate, from 1 (nothing) to 6 (totally, the extent to which major theoretical perspectives influenced their practice: psychoanalysis/psychodynamic, behavior therapy, humanistic, interpersonal and systemic. They were found to be mostly integrative. The means for the major school of psychotherapy were less than one full point from each. Diverse and balanced as it is, the sample should be representative for the broader psychotherapist community.

Survey

Upon accepting the invitation to take the survey, participants were asked to read informed consent (Appendix A). After accepting the terms of consent, they received instructions on their primary task (Appendix B), which was to pay attention to a short video recording of from a clinical session so they could rate the therapist in the video according to some criteria. Next, just before the video, some background information on the client was provided, including her age, general complaint, and the fact that this was her first session with this therapist (Appendix C). See how this was presented to the participants in Appendix E.

Each participant was randomly sorted into one of three experimental groups, with an almost even distribution: a total of 34 were assigned habit validation (HV), 33 habit interruption of emotionality (HIe) and 35 habit interruption of self-presentation (HIsp). Each experimental group exposed the participants therein to a different video.

After watching their assigned videos, participants were asked to rate the therapist through several scales, from 0 (very low) to 9 (very high), with a total of 11 items.

Following these responses, they were asked to watch a second video, which was the same for all the experimental groups. In this video, the client, very emotional, and the therapist share a pleasant moment, which could be construed as a mending or strengthening of their bond as well as a signal that no client was harmed in the making of this film. After watching this video, they were asked whether they felt like increasing, keeping or decreasing or unsure their ratings, now that they had this new information.

Then they were left to fill in some biographic data, mostly optionally and leave a comment.

Videos

All videos were excerpts extracted from the same session. Researchers selected three video excerpts, the first demonstrative of habit validation, the second of habit interruption (of emotionality), and the third of habit interruption (of self-presentation). After the data was collected, a stimulus quality check was performed with the author of the approach, that allocated each video excerpt to the specific category and confirmed them as good enough representatives of the three types of interventions.

Participants would see the client on screen, facing the viewers as if they were in the therapist's seat. The therapist himself was heard, but not seen. The three randomly assigned videos were under two minutes. The final video was one minute long. See Appendix D for transcripts.

Results

Figure 2.
Means of the two approval variables for each experimental group.

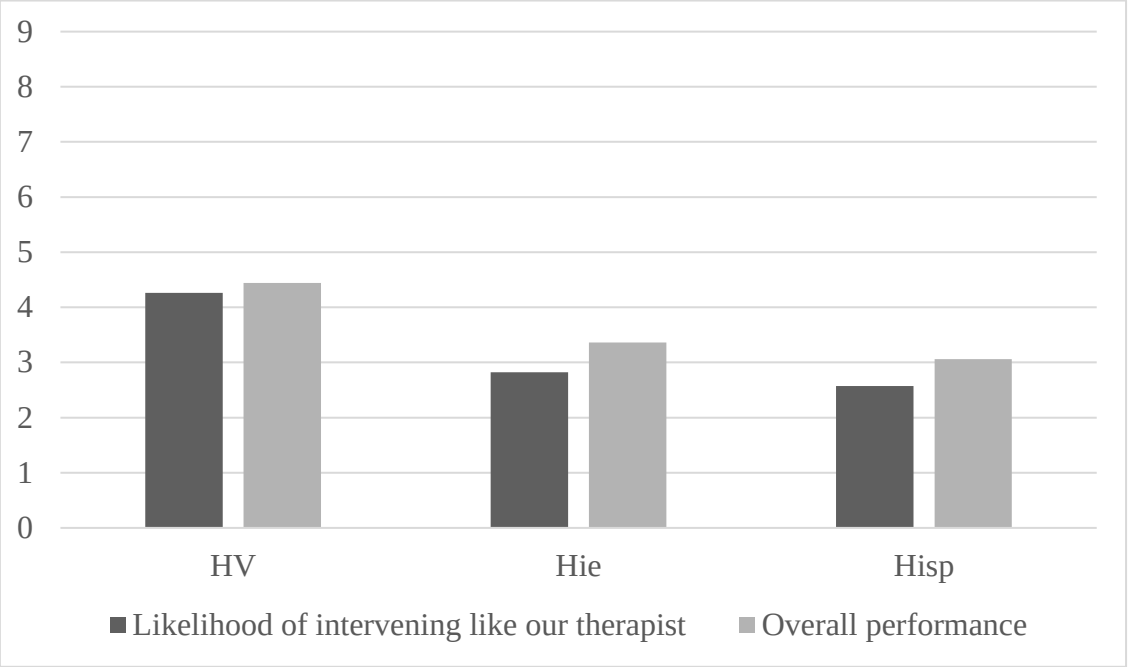


Figure 2 is suggestive of a general trend for the HV group being met with greater therapist approval, as inferred from both these two variables, than either of the HI groups. For the likelihood of intervening like the therapist item, the HV group was scored highest (M = 4.26, SD = .40), followed by HIe (M = 2.82, SD = .35), with HIsp scoring lowest (M = 2.57, SD = .35). For the overall performance rating item, the HV group was also scored highest (M = 4.44, SD = .32), followed by HIe (M = 3.36, SD = .30), with HIsp scoring lowest (M = 3.06, SD = .36).

The mean differences between experimental groups for the self-reported likelihood of intervening like the therapist and the overall performance ratings were extracted and found statistically significant through one-way ANOVA (Tab. 1). Pos Hoc tests with Bonferroni correction came next to find precisely where between the groups were those differences.

Table 1.

One-Way ANOVA results for the therapist approval variables

Variables		Sum of Squares	df	Mean Square	F	*p*
Please rate how likely you'd be to intervene like this therapist.	Between Groups	57,157	2	28,578	6,176	,003
	Within Groups	458,098	99	4,627		
	Total	515,255	101			
Please rate the therapist's overall performance.	Between Groups	36,184	2	18,092	5,004	,009
	Within Groups	357,904	99	3,615		
	Total	394,088	101			

As shown in Table 2, the mean differences for both of those dependent variables were statistically significant between the HV group and each of the HI groups. For the likelihood of intervening like the therapist, the greater difference was between HV and HV1, while the smaller was between HV and HV2. For the overall performance ratings, the greater difference was also between HV and HIe, just as the smaller was also between HV and HV2. There were no significant differences between the interruption groups for either of these two dependent variables.

These results were consistent with previous findings by Lopes (2018). In this new study as in that past one, there appeared to be a clear preference for more validating interventions over interventions that focused on behavioral patterns or habits and, specially, on how to interrupt and change them. But was there data suggesting that people were disconsidering the importance of intervining on clients' habits?

Table 2.
Bonferroni procedure results for the therapist approval variables

Dependent variables	Paired experimental groups for comparison	Mean Difference	SD	*p*
Please rate how likely you'd be to intervene like this therapist.	HV – HIe	1,44652*	,52566	,021
	HV – HIsp	1,69328*	,51798	,004
	HIe – HIsp	,24675	,52195	1,000
Please rate the therapist's overall performance.	HV – HIe	1,07754	,46463	,067
	HV – HIsp	1,38403*	,45784	,010
	HIe – HIsp	,30649	,46135	1,000

Initially, we considered the use of the three items pertaining to the participants' perception of how much the therapist worked on the client's habits to measure habit intervention focus as one global latent variable. We tested the internal consistency for that three item scale and found it good, with a Cronbach's Alpha of .83. A one-way ANOVA showed that the experimental group's effects on this habit intervention focus construct, F (2, 99) = 2.64, p = 0.077, were not significant for our 95% confidence level.

When we explored the issue deeper by testing the items individually, we found one significant effect, F (2, 99) = 7.63, p = 0.001, for the responses to the item "please rate the degree to which the clinician facilitates learning about new patterns or habits". The Bonferroni procedure showed significative differences between HV and either HI groups (Tab. 3). Still, the effects were not significative for the item on learning about old patterns, F (2, 99) = 1.98, p = .143, nor the item on interrupting old patterns, F (2, 99) = .89, p = .413.

Tabela 3.
Bonferroni procedure for the item on "learning about new patterns or habits".

Paired experimental groups for comparison	Mean Difference	S D	*p.*
HV – HIe	1,47326*	,44685	,004
HV – HIsp	1,52521*	,44033	,002
HIe – HIsp	,05195	,44370	1,000

To check if FIS scores could be used to compare our manipulation's effects on each of the three groups , we tested the reliability of a potential FIS scale derived from the seven pertaining items and found a strong Cronbach's Alpha (.90) to support that scale. By scoring each participant's point totals for the seven items regarding perceptions of the therapists' FIS, we produced total FIS perception scores for all participants.

As revealed by one-way ANOVA, our FIS scale's results were found to differ significantly between groups at the $p < .05$ level (Tab. 4). As Table 5 shows, FIS' mean scores were significantly higher for the HV group than for both the HIe group and the HIsp group. FIS' mean scores were not significantly different between the HI groups.

Table 4
One-Way ANOVA results for the FIS scale

	Sum of Squares	Df	Mean Square	F	*p*
Entre Grupos	2227,907	2	1113,953	7,305	,001
Nos grupos	15097,084	99	152,496		
Total	17324,990	101			

Table 5
Bonferroni procedure results for the FIS scale

Paired experimental groups for comparison	Mean Difference	S D	*p*
HV – HIe	8,56150*	3,01766	,017
HV – HIsp	10,81345*	2,97358	,001
HIe – HIsp	2,25195	2,99635	1,000

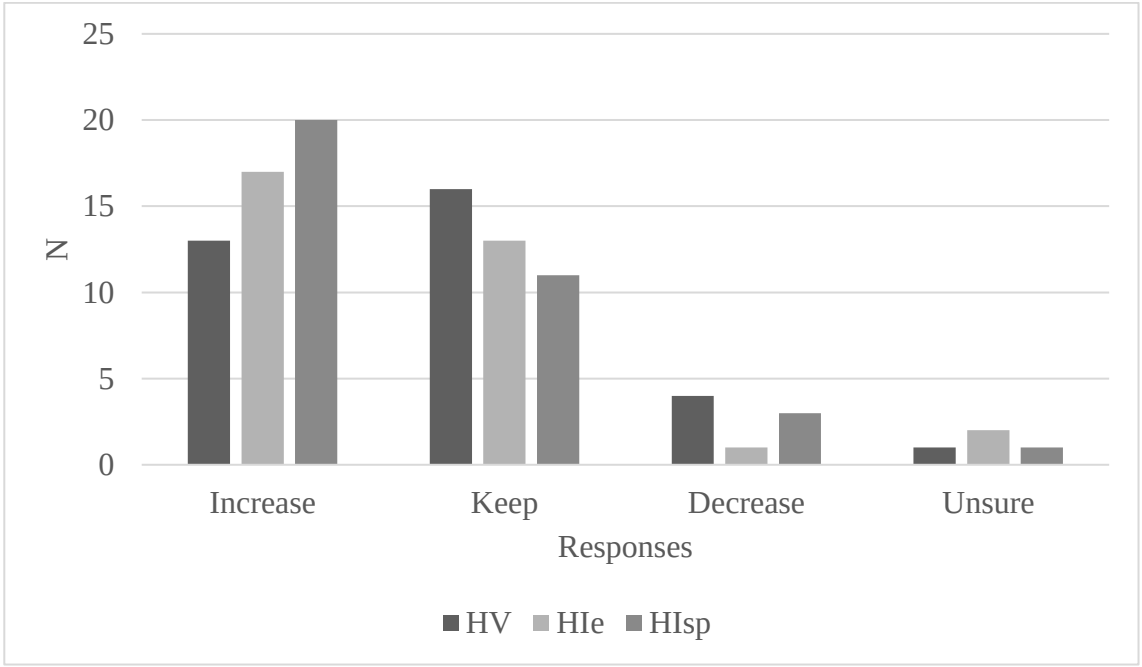
There were experimental manipulation effects for every item in the FIS scale (Tab. 6). The Bonferroni results, displayed on Table 7, showed the effects for each item where not always in the same direction or between the same variables. No mean differences were significative ($p < .05$) between the interruption groups except for the item verbal expression. There were significative mean differences between hope and positive expectations' habit validation and either habit interruption groups. For the rest of the items, there were significative mean differences between the validation group and one

interruption group, but no significative mean difference for the other interruption group. Overall, results were mixed.

To find whether our second video might've changed any participants' general appraisals of the therapist's work with the client, we preformed Chi-Square tests crossing our experimental groups with the four response options the participants faced. The response distributions are displayed in Table 8. The chi-square test indicated, for our confidence level we should reject the null hypothesis that the two variables were independent, X^2 (6, N = 102) = 4,63, p = 0.592. This suggests the experimental manipulation might have caused the different distributions of responses across the experimental groups. A cursory glance over Figure 2 would suggest that the participants slotted into the interruption groups were more likely respond that they would re-evaluate their appraisals positively, following exposure to the second clinical session video excerpt, than the participants slotted into the validation group. More broadly, the bar chart displays more "increase" responses, followed by "keep" responses, and then "decrease" responses.

Figure 3.

Distribution of response frequencies for whether or not participants would change their ratings



Discussion

Overall, the results seem to support our general expectations. Habit validation was met with more widespread approval than the habit interruption interventions, as inferred from the participants' self-reported likelihood of intervening similarly to our expert and from the overall performance rating for each experimental group. This preference is congruent with the trend we expected following results from the previous study (Lopes, 2018).

As to why habit validation was more approved of than habit interruption, results for our focus on habit/pattern scale and facilitative interpersonal skills scale suggest that participants' perception of the expert's niceness weighted more on their judgement than their perception of how focused on habit/pattern the intervention of our expert was. At the extreme, this could imply, at best, that participants might've been very focused on the immediate comfort of the client and the maintenance of the therapeutic alliance by preventing ruptures and, at worse, not focused enough on the promotion of personality change.

While this study focused on the disadvantages of the latter, it should not be understood that validating interventions are worse than habit interruptions. One issue that led to Marsha Linehan's (1993) development of dialectical behavior therapy (DBT) in the 70s, was a relative disadvantage of cognitive behavioral therapy (CBT) in dealing with some difficult-to-treat disorders like recurrent suicidal thoughts and borderline personality: the clients felt too invalidated and so became more avoidant and more likely to drop out – and it's harder to promote personality change if the client doesn't show up. Other times the clients would respond with aggression towards the therapist. The risk of this ruptures incentivized both therapists and clients to avoid tasks which might promote change but produce unpleasantness. Attempts at therapeutic change were punished with withdrawal or aggression while avoidance was reinforced with relief and warmth. So therapists and clients could end up feeling like they were getting to a better place while actually changing less.

Carefully balancing validation and change promotion can be hard but rewarding: DBT was found to be uniquely effective at preventing suicide attempts and also was associated with lower drop-out rates for borderline personality disorder compared to other approaches (Linehan et al., 2006).

This balance is a core aspect of Zoltan Gross' approach. Besides the alleviation of emotional distress being a primary function of therapy, it is the nourishing of the clients'

affect hunger that keeps the client coming back for more. Validation creates, maintains and enhances the therapeutic relationship. It can happen that validation is in itself habit interrupting. As Gross (in press) argued, the nature of the therapeutic dyad can interrupt the expectations of many new clients. These might have learned to expect disrespect and disregard from the people close to them and having the emotional needs of others imposed on them at the cost of their own. But the therapeutic alliance also provides the chance to break the inadequate habituated behavioral patterns the clients bring with them already, which have so far been reinforced precisely because they nourish the clients' affect hunger and replace them with more adequate ones. Ultimately, therapists must be careful of what they are validating and be mindful of the dangers of what they are interrupting.

Nonetheless, character structures are self-perpetuating and emotionally regulating, so meaningful, desirable change can risk causing some emotional dysregulation (Gross, 1992; in press). Rupture risk assessment should inform the therapist's decision, but must be weighted against the potential therapeutic gains. When we consider the participants' responses to whether or not they would change their ratings of our expert, it was in those groups where the interventions seemed riskier (the HI groups) that we observed the greater frequencies for answering they would increase their previous ratings, and the lowest frequencies for answering they would keep those. It might be the second video triggered a re-evaluation of the risks and potential gains of the interventions they previously saw.

Because the second video featured a moment, much more intimate than the situation in the previous video, in which the client affirms her wellness and the client and therapist mend the strain in their relationship, it could drive the point home that ruptures can be overcome and actually enhance the therapeutic alliance (Safran and Muran, 1996; Safran & Muran, 2000; Safran, Muran & Eubanks-Carter, 2011; Stevens, Muran, & Safran, 2003).

Despite it's format and resource limitations, elements of this study can be adopted for more in-depth studies on the subject matter and the same basic format could allow much more wealth of information with few adjustments.

Providing different contexts for the intervention through text before the same video could allow us to test for whether participants' judgements would weight how committed to change the client was and how strong the therapeutic bond already was. these are factors that determine how much strain the therapeutic bond can take and thus how much emotional dysregulation through interruption the client could put up with and

work through (Gross, in press). It's possible that some of our participants underestimated how much strain our client could handle, until they watched the second video where the client and the therapeutic bond itself exhibited their toughness. They might've overestimated the rupture in the alliance. Hence why they would choose to increase their previous ratings after that.

One limitation of this study was the low variety of stimuli. With just one therapist and just one client, for all of our experimental conditions, we cannot control for the effects of each of their idiosyncrasies like we could if we had more therapists and clients to compare them to.

A repeated-measures study design, instead of a between-groups study design as we've conducted, could better tell us how the characteristics each participant is bringing to the table could predict each participant's judgement of the expert in each scenario, though this would require considerably more time and energy from each participant and thus make it harder to conduct for a master's degree dissertation.

Our original scales passed their reliability tests and could be repurposed for similar studies. Still, conducting similar studies with more established materials like FIS would produce results more comparable to those of other studies, than our results are.

This study stands out from other therapists-rating-therapists studies by using Gross' (1992; in press) model for psychotherapy, which hasn't been scrutinized by much quantitative analysis, though it shows great promise and overlaps in major aspects with other models that have already been widely empirically supported (Simões, 2018).

Becoming aware of what makes therapists better is necessary for them to direct their training likewise. Knowing what skills relate to better outcomes is a step in that direction. Some goals seem more intuitive, like knowing how to make the client feel heard and cared for. For the goals that aren't so intuitive and can be initially hard to balance with other goals, like when we must promote personality change by pulling the clients out of their comfort zones while also alleviating their suffering, it takes a good theory to keep therapists from losing sight of their goals and take heed of probable pitfalls. Zoltan Gross (1992; in press) offers one such theory, as we hope we've demonstrated here.

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Appendixes

Appendix A – Consentimento Informado

Dear Clinician

Our research team at Faculty of Psychology, University of Lisbon, invites you to participate in another research study, on clinical decision making, about how clinicians perceive therapist performance focused on clients' patterns or habits.

The participants of this study are clinicians of any theoretical approach.
We designed an experiment for **10 minutes or less**.

We welcome and appreciate your interest and invite you to read the Informed Consent information below before taking part in the survey, which has been through the Ethics Committee.

The platform would randomly allocate you to one experimental or control condition in order to watch a video excerpt (< 2 minutes) from the middle of a real psychotherapy session and rate it. Then you will see the closing of that session (1 minute). Finally, you provide basic demographic info and share your experience of participation.

The responses to this questionnaire will be data for the 1st researcher's dissertation project, in coordination with two other completed projects. The results could potentially be used at conferences and in relevant publications. Your participation is voluntary, and your answers will be anonymous and confidential. We do not know or anticipate risks to your physical or mental health.

If you move on by pressing the "forward" button, we assume that you have read, understood the previous information and have agreed to participate in this research. You can quit at any time. If you have further questions or want to be later informed about the results of the study, please feel free to contact us through the following email: adelinodouradovale@gmail.com

We hope you appreciate the delicate clinical material we prepared with care. Thank you in advance!

Adelino Dourado do Vale (adelinodouradovale@gmail.com)
Supervised by Nuno Conceição (nconceicao@psicologia.ulisboa.pt)
Faculdade de Psicologia, Universidade de Lisboa.

Appendix B – Information on primary task

As mentioned earlier, your collaboration in this research involves the participation on a brief task.

We require you to be in a quiet, comfortable place; mostly free from interruptions and distractions.

Headphones are advised as helpful but not compulsory. Make sure the sound of your computer or device is turned on and balanced to your earing needs.

The following video will be an excerpt from a therapy session. Please pay attention, because you will be asked to rate the therapist's performance according to some criteria, as soon as you finish watching the video.

Appendix C – Background information on client

Joaquina is a young woman, who notices low levels of self-esteem when occasionally more isolated, and is now interested in working on a pattern of feeling insecure about her friendships with other women: "So when I get to know or deepen my relationships with a woman that is very important to me. Then this brings me, sometimes, quite a lot of anxiety in a way that I get very sensitive to rejection cues that might be in the air."

In terms of past history, Joaquina lived with her mother and father until I was about 7 years old. Her mother then left the country and the client started living with her father. The initial travel intention of the mother was to pursue studies abroad during 1 year, but she fell in love with a man, with whom she decided to travel around the world for the next 10 years. During this extended period, Joaquina would occasionally visit the

mother here and there, where she was. The mother finally came back to their homeland, when Joaquina was 17. At that time, she decided to go abroad for studies. Joaquina is now 21 living and studying in Holland. She had a first therapeutic process of three years of weekly sessions with a psychodynamic female therapist and is now on her second process with an integrative therapist.

Appendix D - Transcripts for each video excerpt

HV – Habit validation

JOAQUINA: But then I remember the first year and the second year it was like – it was really, really sad. I think I'll never experience such a pain again in my life.

ZOLTAN GROSS: Ah, that was very painful.

JOAQUINA: Physically painful. I felt like I was dying. Like there was always something missing inside of myself. And this pain of just wanting to touch something and seeing it is not there.

ZOLTAN GROSS: [15:55 in full video] Ah, you really missed her a lot.

JOAQUINA: Yes, hm-hm.

ZOLTAN GROSS: Yah, and did you cry a lot in the first year.

JOAQUINA: Yes, a lot, a lot. I used to cry a lot, hm-hm.

ZOLTAN GROSS: You missed her.

JOAQUINA: Yeah, I missed her and I cried. At some point I was young, I was very much into heavy metal and I started dressing all in black and that gave me power, that kind of music, so I felt a bit more powerful.

ZOLTAN GROSS: Ah. Heavy metal was kind of angry too.

JOAQUINA: Eheh, yes. Eheheh. But I never got angry. It was only when I started doing therapy later on, when I was seventeen, that I could get angry for the first time, at both my parents. Eheheh.

ZOLTAN GROSS: Ah, yeah, but you have a very sweet smile, and you turned into a very dear girl.

JOAQUINA: Eheheh, thank you.

HIe – Interruption of self-presentation

JOAQUINA: Still, this difficulty I have sometimes with my women friends. Because now, the women I have around me in Holland, they are very caring for me and they love me a lot.

ZOLTAN GROSS: Ah, that's good.

JOAQUINA: Although I still feel this nervousness when I try to get closer to them specially physically. Like when I try to hug them or if we are, for example, watching a movie together and we get very close in the couch. I love it a lot and I want more closeness. But I start feeling so nervous, like in a first date or something, like a little baby.

ZOLTAN GROSS: Ah, that's really difficult. Because my guess is when you are with your loving female friends, in Holland, and you enjoy the warmth that you are getting from them, and you probably want to have more – wouldn't it be nice to have warmth?

JOAQUINA: Yes.

ZOLTAN GROSS: Sometimes, I don't think they understand what it is that you want. They make you feel uncomfortable about you wanting to be closer to them than you are used to being close. See, I don't think that they recognize what it is like to have a friend who wants to be their loving daughter.

JOAQUINA goes quiet for a long break.

HIsp – Interruption of emotion

ZOLTAN GROSS: But, as a child, it is very hard to be angry, particularly when you are deserted by your mother.

JOAQUINA: Yes, uh-uh. And I feel about anger, hm, it is easier with my friends now, in Holland, to show disagreement. But it is still special with my mom.

ZOLTAN GROSS: But there is a difference between showing disagreement and being mad.

JOAQUINA: Uh-uh. Eheheheh.

ZOLTAN GROSS: And when they hurt your feelings it is hard for you to say back at them “you hurt me”. And I don’t like you for doing that. Right? Or something like that.

JOAQUINA: Yes, it is difficult to do that. I tend to think if I just tell them how I feel and, in a peaceful way, that is enough. I shouldn’t change them. Or try to ask them to change their behavior. That is just how they are supposed to be.

ZOLTAN GROSS: Sure. If you get mad at them, they are going to desert you just like your mother did.

JOAQUINA goes quiet for a long break.

Mending of the alliance

ZOLTAN GROSS It was a hard time. And those hard times continue to live inside of people even though they don’t know it and it comes out in strange ways. In different ways. And I think in your case, the loss of your mother continues to operate in your current relationships. The tragedy of her loss makes you very sensitive to being rejected by your friends.

JOAQUINA Hm-hm.

ZOLTAN GROSS What is goin on, what are you feeling?

JOAQUINA tearing up: A little bit – hum – sad.

ZOLTAN GROSS Yeah?

JOAQUINA Hm-hm.

ZOLTAN GROSS I hope you’ll forgive me.

JOAQUINA Eheheh. Yes, I will.

Appendix E – The survey as presented to the participants

U LISBOA | UNIVERSIDADE DE LISBOA

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Our research team at Faculty of Psychology, University of Lisbon, invites you to participate in another research study, on clinical decision making, about how clinicians perceive therapist performance focused on clients' patterns or habits.

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Thank you in advance!

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Supervised by Nuno Conceição (nconceicao@psicologia.ulisboa.pt)
Faculdade de Psicologia, Universidade de Lisboa.

>>

As mentioned earlier, your collaboration in this research involves the participation on a brief task.

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Headphones are advised as helpful but not compulsory. Make sure **the sound of your computer or device is turned on** and balanced to your earing needs.

The following video will be an excerpt from a therapy session. Please pay attention, because you will be asked to rate the therapist's performance according to some criteria, as soon as you finish watching the video.

>>

Some background on the client you are about to watch:

Joaquina is a young woman, who notices low levels of self-esteem when occasionally more isolated, and is now interested in working on a pattern of feeling insecure about her friendships with other women: “So when I get to know or deepen my relationships with a woman that is very important to me. Then this brings me, sometimes, quite a lot of anxiety in a way that I get very sensitive to rejection cues that might be in the air.”

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Please refrain from interrupting your viewing if possible.

I have seen the video, take me to the questions. (PRESS HERE TO CONTINUE)

>>

Please rate how likely you'd be to intervene like this therapist.

Extremely unlikely — Extremely likely
0 1 2 3 4 5 6 7 8 9

Please rate the therapist's overall performance.

Very low — Very high
0 1 2 3 4 5 6 7 8 9

Please rate how much the clinician fosters and facilitates learning about old automatic patterns or habits.

Not at all — A lot
0 1 2 3 4 5 6 7 8 9

Please rate how much the clinician fosters and facilitates interrupting old automatic patterns or habits.

Not at all — A lot
0 1 2 3 4 5 6 7 8 9

Please rate the degree to which the clinician facilitates learning about new patterns or habits.

Not at all — A lot
0 1 2 3 4 5 6 7 8 9

>>

Please rate how at-ease (clarity, cadence, lack of anxiety) the psychologist is while communicating.

Not at all 0 1 2 3 4 5 6 7 8 A lot 9

Please rate how able the psychologist is of demonstrating interest for the client and react accordingly to the conversation, to facilitate emotional engagement.

Not at all 0 1 2 3 4 5 6 7 8 A lot 9

Please rate how able the psychologist is of conveying a clear, organized understanding of the client's situation and express *novel* points of view and rationales that are logically sound, convincing and agreeable.

Not at all 0 1 2 3 5 6 7 8 A lot 9

Please rate how able the psychologist is of conveying concern and acceptance to his patient - without being judgemental, condescendent, rude, disaproving, guilt-inducing, exasperated or annoyed.

Not at all 0 1 2 3 4 5 6 7 8 A lot 9

Please rate how encouraging the psychologist is, how well he can convey that the client is a capable person and that the client's goals are attainable.

Not at all
0 1 2 3 5 6 7 8 9 A lot

Please rate how *accurately* and *timely* the psychologist offers reflections that he is paying attention and understanding what the client is feeling and saying.

Not at all
0 1 2 3 4 5 6 7 8 9 A lot

Please rate how much the psychologist contributes to promote cooperation by creating opportunities to work together as a team, sharing responsibilities, goals and valuing the client's contributions.

Not at all
0 1 2 3 4 5 6 7 8 9 A lot

>>

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You now have the chance to see one more minute of the session, closer to its end:

After this excerpt, would you increase, keep, or decrease your previous rating of the therapist's overall performance?

- Increase
- Keep
- Decrease
- Unsure

>>

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Please fill in some information about yourself.

Gender

Male

Female

Other

Age:

Nationality:

Race/Ethnicity (Check as many as apply)

White/Caucasian (Europe)

African

Asian/Pacific Islander

Indigenous Australians

Hispanic

Middle Eastern

Native American/Alaska Native

Multiethnic (please specify)

International (please specify)

Other

Profession (Check as many as apply)

Psychiatrist

Psychologist

Psychotherapist

Counselor

Social worker

Other

If you are a psychologist: In your practice, how much do you think you are influenced by each one of the following theoretical perspectives? (Please rate all the scales below)

	Nothing 1	2	3	4	5	Totally 6
Psychoanalysis/Psychodynamic	○	○	○	○	○	○
Behavior Therapy	○	○	○	○	○	○
Cognitive Therapy	○	○	○	○	○	○
Humanistic Therapy	○	○	○	○	○	○
Interpersonal Therapy	○	○	○	○	○	○
Systemic Therapy	○	○	○	○	○	○
Other (Specify approach or model):	○	○	○	○	○	○
Other (Specify approach or model):	○	○	○	○	○	○
Other (Specify approach or model):	○	○	○	○	○	○
Other (Specify approach or model):	○	○	○	○	○	○
To what extent do you regard your orientation as eclectic or integrative?	○	○	○	○	○	○

Years of clinical experience:

>>

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Lastly, we are interested to know about your experience of participating in our study. What was your motivation when you decided to participate? What was it like for you to answer all these questions? How is it like for you now that you have participated?

Please press the » next page button so your data can be recorded.

>>

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We thank you for your time spent taking this survey.
Your response has been recorded.

Names were changed and video stills were blocked to protect isentity of our volunteer client.

Tables

Table 6

ANOVA results for each FIS scale item

FIS dimension	Survey Item		Sum of Squares	df	Mean Square	F	*p*
Verbal Expression	Please rate how at-ease (clarity, cadence, lack of anxiety) the psychologist is while communicating.	Between Groups	123,618	2	61,809	12,338	,000
		Within Groups	495,960	99	5,010		
		Total	619,578	101			
Emotional Expression	Please rate how able the psychologist is of demonstrating interest for the client and react accordingly to the conversation, to facilitate emotional engagement.	Between Groups	57,703	2	28,852	6,294	,003
		Within Groups	453,787	99	4,584		
		Total	511,490	101			
Persuasion	Please rate how able the psychologist is of conveying a clear, organized understanding of the client's situation and express novel points of view and rationales that are logically sound, convincing and agreeable.	Between Groups	45,178	2	22,589	4,286	,016
		Within Groups	521,812	99	5,271		
		Total	566,990	101			
Warmth, Acceptance and Understanding	Please rate how able the psychologist is of conveying concern and acceptance to his patient - without being judgemental, condescendent, rude, disaproving, guilt-inducing, exasperated or annoyed.	Between Groups	59,574	2	29,787	5,410	,006
		Within Groups	545,093	99	5,506		
		Total	604,667	101			
Hopefulness and Positive Expectations	Please rate how encouraging the psychologist is, how well he can convey that the client is a capable person and that the client's goals are attainable.	Between Groups	90,153	2	45,077	9,395	,000
		Within Groups	474,994	99	4,798		
		Total	565,147	101			
Empathy	Please rate how accurately and timely the psychologist offers reflections that he is paying attention and understanding what the client is feeling and saying.	Between Groups	37,416	2	18,708	3,224	,044
		Within Groups	574,545	99	5,803		
		Total	611,961	101			
Alliance-bond capacity	Please rate how much the psychologist contributes to promote cooperation by creating opportunities to work together as a team, sharing responsibilities, goals and valuing the client's contributions.	Between Groups	37,459	2	18,729	4,668	,012
		Within Groups	397,247	99	4,013		
		Total	434,706	101			

Table 7

Bonferroni procedure results for each FIS scale item

FIS dimension	Paired experimental groups for comparison	Mean Difference	S D	*p*
Verbal fluency	HV – HIe	-,04278	,54695	1,000
	HV – HIsp	2,29748*	,53896	,000
	HIe – HIsp	2,34026*	,54309	,000
Emotional Expression	HV – HIe	1,21658	,52318	,066
	HV – HIsp	1,79580*	,51554	,002
	HIe – HIsp	,57922	,51948	,803
Persuasion	HV – HIe	,55348	,56102	,979
	HV – HIsp	1,59244*	,55283	,015
	HIe – HIsp	1,03896	,55706	,195
Warmth, Acceptance and Understanding	HV – HIE	1,85829*	,57340	,005
	HV – HIsp	1,19076	,56503	,113
	HIE-HIsp	-,66753	,56935	,732
Hopefulness and Positive Expectations	HV – HIe	2,09804*	,53526	,000
	HV – HIsp	1,87899*	,52745	,002
	HIe – HIsp	-,21905	,53148	1,000
Empathy	HV – HIe	1,39929	,58869	,058
	HV – HIsp	1,13782	,58009	,158
	HIe – HIsp	-,26147	,58453	1,000
Alliance-bond capacity	HV – HIe	1,47861*	,48950	,010
	HV – HIsp	,92017	,48235	,178
	HIe – HIsp	-,55844	,48604	,760